STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155106	A. BUILDING _____ B. WING _____	C 02/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERWALK VILLAGE	295 WESTFIELD ROAD NOBLESVILLE, IN 46060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00085598. Complaint Number IN00085598: Substantiated, Federal/State deficiencies related to the allegation are cited at F281 and F514. Survey Dates: February 14 and 15, 2010 Facility Number: 000044 Provider Number: 155106 AIM Number: 100274940 Survey Team: Vanda Phelps, R.N. Census Bed Type: SNF/NF: 152 Total: 152 Census Payor Type: Medicare: 15 Medicaid: 105 Other: 32 Total: 152 Sample: 3 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on February 17, 2011 by Bev Faulkner, RN	F 000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567L Plan of Correction be considered the Letter of Credible Allegation and requests a Desk Review in lieu of a Post Survey review on or after March 8, 2011. RECEIVED MAR - 7 2011 LONG TERM CARE DIVISION INDIANA STATE DEPARTMENT OF HEALTH	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility	F 281		

Appr Remote 03-09-11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Executive Director | (X6) DATE: 3-2-11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155106	A. BUILDING _____ B. WING _____	C 02/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERWALK VILLAGE	295 WESTFIELD ROAD NOBLESVILLE, IN 46060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 1 must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews, the facility failed to ensure 1 of 3 sampled residents received care in accordance with professional standards in that she did not consistently receive her medications as ordered by the physician. At least 2 of the 7 nurses who attended this resident documented administration of the 9 p.m. medication although they had not given it. (Resident C) Findings include: The code book for the Indiana State Board of Nursing 2008 Edition was reviewed on 2/16/2011 at 12 noon. On page 45, under the section for Licensed Practical Nurses, under unprofessional conduct, the following statement indicated: "Sec (section) 3. Nursing behaviors (acts, knowledge, and practices) failing to meet the minimal standards of acceptable and prevailing licensed practical nursing practices, which could jeopardize the health, safety, and welfare of the public shall constitute unprofessional conduct. These behaviors shall include, but are not limited to, the following: (6) Falsifying, omitting, or destroying documentation of nursing actions on the official patient/client record." Resident C was observed in bed during the orientation tour on 2/14/2011 at 2:40 p.m. Clinical record review for Resident C was done 2/15/11 at 4 p.m. Her 10/13 2011 significant change RAI (Resident Assessment Instrument)	F 281	**F281 – Professional Standards**: It is the consistent practice of this Provider to ensure the services provided or arranged meet professional standards of quality. **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice** Resident C's physician was immediately notified and assessed the alleged incident finding that no negative impact nor action needed to be taken. **How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken** Residents who have medications ordered by physicians have the potential to be affected by the same alleged practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155106	A. BUILDING _____ B. WING _____	C 02/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERWALK VILLAGE	295 WESTFIELD ROAD NOBLESVILLE, IN 46060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 2 indicated she was severely impaired cognitively, unable to ambulate, turn herself in bed, or do any self care. She could not communicate verbally. Interview of Resident C's POA (Power of Attorney) on 2/15/11 at 8:17 a.m., indicated she noticed in October 2010 the resident was being billed for Mirtazapine, brand name Remeron, by two different pharmacies. The original physician's order was dated 8/17/2010. The order was for Mirtazapine 15 mg. (milligrams) to be given as 1/2 tablet/7.5 mg. orally on a daily basis at bedtime (9 p.m.) They were billed for 30 tablets on 8/22/10 from the facility's pharmacy provider. The medication was reordered on 10/10/10 for another 30 day supply from the facility pharmacy and again on 10/19/10 for a 90 day supply from the resident's personal choice, a mail order pharmacy. Another 30 day supply was ordered from the facility pharmacy on 12/3/10. The POA indicated she discussed the problem with staff nurses but no improvement was noted. The POA indicated she then discussed this issue with the Director of Nursing on 1/18/2011, at which time was told they would "look into it." She indicated the Director of Nursing called her on 1/19/2011 and said they had "agreed there was a discrepancy and would investigate...and confirmed the records had been falsified." Interview with staff at the facility's choice pharmacy on 2/16/11 at 2:52 p.m., indicated their records showed Resident C's Mirtazapine/Remeron had been dispensed as 15 mg. tablets already broken into half tablet doses and a 30 day supply was dispensed, i.e. total of 15 tablets. She added, "That is our standard protocol when half-tablet doses are prescribed."	F 281	The facility pharmacy conducted audits of other residents to identify and ensure medications were given as ordered. Facility nursing managers provide daily overview validating medications are given as ordered. Nursing Staff were re-educated on the expected standards on documentation and med pass procedures. Non-compliance with facility policy and procedures may result in employee re-education and/or disciplinary action up to and including termination **What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur** Residents receiving medications from an alternative pharmacy are identified in resident record for staff awareness to ensure consistent	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155106	A. BUILDING _____ B. WING _____	C 02/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERWALK VILLAGE	295 WESTFIELD ROAD NOBLESVILLE, IN 46060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 3 An interview with the Administrator and the Director of Nursing occurred on 2/15/2011 at 12:35 p.m. They indicated the investigation had included an audit of the medications in comparison with the resident's MARs (Medication Administration Records) and the amount of medication on hand. The bottle of 90 tablets, ordered on 10/19/10 was located within the medication cart, in an overflow drawer, unopened. They reviewed this resident's MARs from August 2010 through January 2011. The MARs were documented to indicate Resident C had received a dose of Remeron every night at 9 p.m. However, the conclusion was that some of the doses had been documented as given, although there had not been medication available, except the unopened bottle of 90 which had not been used. They had interviewed the seven nurses who had worked that shift on that hall who would be the responsible parties. Two nurses had admitted to having charted the Remeron as given although they had not given it "because it was not available." Because it was impossible to know exactly when the doses were missed, it was impossible to determine how far the scope of unprofessional behavior had gone. Two nurses (LPN #1 and LPN #6) had been given "final written notices" as disciplinary measures and the others who each vehemently denied wrong doing, had been given "verbal counseling." In addition, the Director of Nursing indicated the Remeron was now on a sign out sheet and counted each shift, like narcotic protocol. Other charts had been audited for similar problems, but none were found. The Unit Manager indicated 2/15/11 at 5:40 p.m., they had put a flag in Resident C's MAR alerting the staff to reorder her	F 281	delivery of medications without interruption. Nursing Staff were re-educated on the expected standards on documentation and med pass procedures Non-compliance with facility policy and procedures may result in employee re-education and/or disciplinary action up to and including termination **How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place** A medication review CQI will be used daily 2 weeks, weekly x4 and then quarterly thereafter. The governing CQI committee will review the data for any required or further follow up, action plan or re-education. The Director of Nursing and/or designee is responsible for ongoing monitoring. **Compliance date: March 8, 2011**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155106	A. BUILDING _____ B. WING _____	C 02/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERWALK VILLAGE	295 WESTFIELD ROAD NOBLESVILLE, IN 46060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 4	F 281		

medications from the mail order pharmacy so that this could not be repeated.

Interview with the Nurse Practitioner attending Resident C was conducted on 2/15/11 at 1:15 p.m. He indicated there had been no harmful effects to Resident C as a result of inconsistently receiving this medication. He said the medication ordered was a hopeful trial to stimulate her appetite and meal intake. He further indicated that he was alerted to this issue the same day the administrative staff had become aware. "There were stacks of charts and pharmacy forms everywhere."

Clinical record review for Resident C was done 2/15/11 at 4 p.m. It indicated she was admitted 3.5 years earlier and her primary diagnosis was end stage Alzheimer's dementia, dysphagia (difficult swallowing) and unavoidable weight loss. She is under the care of a hospice service. Review of the physician orders indicated Mirtazapine/Remeron 15 mg. had been originally ordered on 8/17/10 to be given in 1/2 tablets/7.5 mg. each day at bedtime. Review of the November, December 2010 and January 2011 MARs indicated a nurse had initialed each dose as given, except for blanks on January 2 and 25 and circled initials on December 1-2-3, 2010. A notation on the back of this form was dated 12/3/10 "Mirtazapine unavailable-pharmacy notified."

The Director of Nursing indicated neither nurse who admitted they had falsely documented giving the Mirtazapine/Remeron gave rationale for this action. Neither LPN #1 nor LPN #6 was available for interview.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155106	A. BUILDING _____ B. WING _____	C 02/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERWALK VILLAGE	295 WESTFIELD ROAD NOBLESVILLE, IN 46060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 5 This federal tag relates to complaint number IN00085598. 3.1-35(g)(1)	F 281		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure all nursing documentation was accurate for 1 of 3 sampled residents regarding medication administration. (Resident C) Findings include: Resident C's POA (Power of Attorney) was interviewed on 2/15/11 at 8:17 a.m. She said she had noticed in October 2010 the resident was being billed for Mirtazapine, brand name Remeron, by two different pharmacies. The original physician's order was dated 8/17/2010.	F 514	**F514 – Resident Records – Accurate/Complete**: It is the consistent practice of this Provider to ensure clinical records are maintained on each resident that are complete, accurately documented, readily available and systematically organized. **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice** Resident C's physician was immediately notified and assessed the alleged incident finding that no negative impact nor action needed to be taken to this resident. **How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken** Residents who have medications ordered by physicians have the potential to be affected by the same alleged practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155106	A. BUILDING _____ B. WING _____	C 02/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERWALK VILLAGE	295 WESTFIELD ROAD NOBLESVILLE, IN 46060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 6 This medication is an antidepressant medication with an additional use of stimulating appetites. The order was for Mirtazapine 15 mg. (milligrams) to be given as 1/2 tablet/7.5 mg. orally on a daily basis at bedtime (9 p.m.) They were billed for 30 tablets on 8/22/10 from the facility's pharmacy provider. The medication was reordered on 10/10/10 for another 30 day supply from the facility pharmacy and again on 10/19/10 for a 90 day supply from the resident's personal choice pharmacy, a mail order pharmacy. Another 30 day supply was ordered from the facility pharmacy on 12/3/10. The POA indicated she discussed the problem with staff nurses but no improvement was noted. The POA indicated she then discussed this issue with the Director of Nursing on 1/18/2011 at which time was told they would "look into it." She indicated the Director of Nursing called her on 1/19/2011 and said they had begun an investigation and "agreed there was a discrepancy and would investigate further...and confirmed the records had been falsified." Interview with staff at the facility's choice pharmacy on 2/16/11 at 2:52 p.m., indicated their records showed Resident C's Mirtazapine/Remeron had been dispensed as 15 mg. tablets already broken into half tablet doses and a 30 day supply was dispensed, i.e. total of 15 tablets. She added, "That is our standard protocol when half-tablet doses are prescribed." An interview with the Administrator and the Director of Nursing occurred on 2/15/2011 at 12:35 p.m. They indicated the investigation had included an audit of the medications in comparison with the resident's MARs (medication administration records) and the amount of	F 514	The facility pharmacy conducted audits of other residents to identify and ensure medications were given as ordered. Facility nursing managers provide daily overview validating medications are given as ordered. Nursing Staff were re-educated on the expected standards on documentation and medication pass procedures. Non-compliance with facility policy and procedures may result in employee re-education and/or disciplinary action up to and including termination **What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur** Residents receiving medications from an alternative pharmacy are identified in resident record for staff awareness to ensure consistent	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155106	A. BUILDING _____ B. WING _____	C 02/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERWALK VILLAGE	295 WESTFIELD ROAD NOBLESVILLE, IN 46060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 7	F 514		

medication on hand. They had reviewed the records from August 2010 through January 2011 and had included a random sampling of other residents for review as well. Resident C's bottle of 90 tablets, ordered on 10/19/10 was located within the medication cart in an overflow drawer, unopened. The MARs documentation indicated Resident C had received a dose of Remeron every night at 9 p.m. However, the conclusion was that some of the doses had been documented as given, although there had not been medication available, except the unopened bottle of 90 which had not been used. They had interviewed the seven nurses who had worked that shift on that hall who would be the responsible parties. Two nurses admitted to having charted the Remeron as given although they had not given it "because it was not available." The Director of Nursing indicated neither nurse who admitted they had falsely documented giving the Mirtazapine/Remeron gave rationale for this action. Neither LPN #1 nor LPN #6 was available for interview.

Interview with the Nurse Practitioner attending Resident C was conducted on 2/15/11 at 1:15 p.m. He indicated there had been no harmful effects to Resident C as a result of inconsistently receiving this medication. He said it was a hopeful trial to stimulate her appetite and meal intake.

Clinical record review for Resident C was done 2/15/11 at 4 p.m. It indicated she was admitted 3.5 years earlier and her primary diagnosis was end stage Alzheimer's dementia, dysphagia (difficult swallowing) and unavoidable weight loss. She is under the care of a hospice service. Review of the physician orders indicated

delivery of medications without interruption.

Nursing Staff were re-educated on the expected standards on documentation and med pass procedures

Non-compliance with facility policy and procedures may result in employee re-education and/or disciplinary action up to and including termination

How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place

A medication review CQI will be used daily 2 weeks, weekly x4 and then quarterly thereafter. The governing CQI committee will review the data for any required or further follow up, action plan or re-education.

The Director of Nursing and/or designee is responsible for ongoing monitoring.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155106	A. BUILDING _____ B. WING _____	C 02/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERWALK VILLAGE	295 WESTFIELD ROAD NOBLESVILLE, IN 46060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 8 Mirtazapine/Remeron 15 mg. had been originally ordered on 8/17/10 to be given in 1/2 tablets/7.5 mg. each day at bedtime. Review of the November, December 2010 and January 2011 MARs indicated a nurse had initialed each dose as given, except for blanks on January 2 and 25 and circled initials on December 1-2-3, 2010. A notation on the back of this form was dated 12/3/10 "Mirtazapine unavailable-pharmacy notified." This federal tag relates to complaint number IN00085598. 3.1-50(a)(2)	F 514	**Compliance date: March 8, 2011**	